

Kalm Care Ltd

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 23 January 2018, and was unannounced. This was the first inspection of this service since they started to provide regulated activities in January 2017.

Kalm Care Ltd provides care and support to people with mental health needs living in two houses so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. This was the first inspection of this service.

On the day of the inspection there were seven people living at the service across the two houses.

The service had a registered manager, which is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they liked living at the service and mental health professionals were positive about the service offered to people they placed there. Although staff understood about the types of abuse that can occur, the registered manager acknowledged the service needed to be more proactive when incidents took place between people living at the service and consider that there may be safeguarding concerns.

There were gaps in the risk assessment process. Although there were some risk assessments in place for people, some lacked sufficient detail to provide guidance to staff in managing people's risks. For some areas of risk there were no risk assessments in place at all to guide staff. Subsequent to the inspection the registered manager updated risk assessments to provide detail and put in place new risk assessments to fill the gaps.

The registered manager had reviewed medicines management prior to the inspection and identified some issues. Medicines management had improved by the time of the inspection but there were still some issues we identified with recording on medicine administration records, issues which had been identified earlier by the registered manager but still remained.

We identified issues with recruitment as up to date criminal checks were not in place at the time of the service being registered with CQC, although these had been obtained by the time of the inspection. We were not confident all checks had been undertaken to ensure staff had the right to work in the UK.

Staff received regular supervision and training and told us the registered manager was supportive. Mental health professionals told us staff and the registered manager had the skills and knowledge to carry out their roles.

People's needs were identified and responded to well. The service was effective at working in co-operation with other organisations to deliver care and support. This included where people's needs had changed, and where people needed ongoing healthcare support.

Care records were up to date and were reviewed annually and more often when people's needs changed. There were quality audits in place and the registered manager was in the process of introducing more audits in line with the provider policy. The registered manager told us they were formalising new systems as part of the move to being a regulated service and they were not all in place as yet. The registered manager was keen to learn from incidents that took place and we could see evidence of this.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems at the service supported this practice. Staff understood the importance of consent and people were supported to be as independent as possible. People signed their care records and were involved in planning their care.

We found the provider was in breach of three fundamental standards. These related to safe care and treatment, recruitment, and the requirement to notify CQC of significant events.

We have made one recommendation in relation to staff training.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. There were not detailed risk assessments in place to guide staff in their caring role.

There were systems in place to safeguard people but they were not being fully implemented at the time of the inspection which could place people at risk of harm.

Medicines were not always recorded as administered safely, although this had improved by the time of the inspection.

By the time of the inspection there were sufficient references and up to date DBS' in place but these had been obtained after the service had been registered with CQC, so staff recruitment was not always safe.

The provider ensured people were protected from the risk of infection.

Requires Improvement 

Is the service effective?

The service was effective. The service worked in partnership with other organisations to deliver good care and support.

People were at liberty to leave the premises as they wished.

Staff received regular supervision and had undertaken training to carry out their role.

People managed their own food and meals but staff were available to provide support if necessary.

Good 

Is the service caring?

The service was caring. People were treated with kindness and staff were caring.

People's views were invited in how the service was run.

The service promoted people's independence and ensured people's privacy and dignity was respected and promoted.

Good 

Is the service responsive?

Good ●

The service was responsive. People's changing needs were identified and responded to well.

People received personalised care that was responsive to their needs.

The provider had a complaints policy in place and had dealt with complaints logged in a timely manner.

Is the service well-led?

Requires Improvement ●

The service was not always well-led. The registered manager was still adapting to managing a service regulated by CQC and had not changed all the necessary systems to reflect those requirements. The provider had not notified CQC of events involving the police without prompting from the CQC inspector.

The registered manager was well regarded by health professionals working with the service.

Kalm Care Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 January 2018, and was undertaken by one adult social care inspector.

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often at one of the supported living schemes as part of their managerial roles. We needed to be sure that they would be available for the inspection visit.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law.

Inspection site visit activity started and ended on 23 January 2018. It included a visit to the provider's office and to one of the houses in which people are supported. We reviewed three care records, two staff files and supervision and training records for two staff. We looked at policies and procedures, quality audits, incident and accident logs and complaints. We spoke with the registered manager and two members of staff on the day of the inspection. We also carried out observations of people's interactions with staff.

There were seven people living in two houses at the time of our inspection visit. Only three people chose to speak with us, however not all these people could answer questions we put to them due to their mental health or communication needs. We spoke with these people in person on 23 January 2018.

Following the inspection the registered manager sent us updated risk assessments and additional information to evidence management actions.

We spoke with three mental health professionals and one family member and obtained feedback from them on the service.

Is the service safe?

Our findings

We asked people if they felt safe living at the service. They told us "very good" and "yes".

There were policies in place at the service to safeguard people but they were not always being implemented. The provider was not following their policy and ensuring a multi-agency safeguarding alert form was completed whenever an incident took place at the services.

For example, on 25 December 2017 there was an incident between two people which should have been notified to the care co-ordinator in line with the provider safeguarding procedures and CQC. We found evidence of another incident in June 2017 where the provider policy was not followed. We discussed these events and the possibility that some people living at the house were not being safeguarded from the actions of others, with the registered manager.

Following the inspection the registered manager spoke with the care co-ordinator regarding the incident on 25 December who told them it did not meet the threshold for a safeguarding investigation.

The registered manager undertook to ensure that the care co-ordinator was contacted in all future incidents involving violence and safeguarding alerts would be made to the local authority and CQC. The local authority would then determine if the event met the threshold for a safeguarding investigation. They also undertook to discuss safeguarding with staff as one staff member was not clear that assaults between people living at the service could be considered a safeguarding event.

One staff member did not understand what whistleblowing was, although all staff understood the different types of abuse and knew what to do if they had any concerns regarding a person.

There were generic risk assessments in place which identified a range of areas of possible risk, for example, mental health, substance misuse and non-compliance with medicines. There were detailed risk assessments in place for some areas of risk identified, for example, a crisis relapse and contingency form for people's mental health, but there were gaps in other areas of risk identified and some risk assessments lacked detail to make them useful for staff.

For example, there was no guidance for staff in how to manage a person who had been unwell and had been hoarding rubbish and items from the street in their room. Therefore if this issue re-occurred there was no record of what had worked well with this person to assist them in clearing the rubbish. We also found there was no risk assessment in place to address the forensic histories for two people, and there was therefore no detailed information for staff in how to manage these risks. Following the inspection the registered manager had completed risk assessments in these areas to provide guidance for staff in managing these behaviours.

Although people were not allowed to smoke in the house we visited, some clearly did. There were no risk assessments in place to address the risks posed by this, although there was a working smoke alarm in place.

The service administered medicines for some people, and others managed their own medicines. Staff had undergone competency assessments in giving medicines. At the service we visited we found medicines were locked away safely and medicine administration records (MAR) were in place. Records of temperatures were not kept but the registered manager was a qualified nurse and knew that the medicines at the service were safely stored at room temperature. However, subsequent to the inspection records of temperature are now being taken daily.

However, we found one medicine had been signed for as given before the due time on the day of the inspection. We found two MAR sheets had been partially written over so it was not possible to read them which was not best practice, and could place people at risk. We discussed this with the registered manager who told us they had addressed the issue of recording legibly on MAR once already with care staff, but a recent MAR showed this practice was still occurring. This meant that staff had not embedded this learning despite being assessed as competent to administer medicines. We also found that up to November 2017 staff were simply ticking medicines as given on the MAR as opposed to putting their initials. This was of concern as it was unclear who had administered the medicines, and this could pose a safety risk.

These concerns were a breach of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that staff recruitment was not always safe as the provider had not carried out Disclosure and Barring Service (DBS) at the time of recruiting staff. In the two staff files we reviewed, one staff member's DBS was dated 2012 although they started working in 2015. The other staff member's check was dated 2009. The service was registered with CQC in January 2017. We also found that both staff did not have two references in place at the point of the service being registered with CQC although the recruitment policy stipulated two references were required. By the time of the inspection there were up to date DBS checks in place and two references for all staff. There was no evidence of the right to work in the UK for one member of staff. This staff member left the service following the inspection so the registered manager was not able to ask for this information, but this showed that at the point of employing them they had not carried out this check which is a requirement by law.

The registered manager told us that the staff they had recruited had both worked at a local service for people with mental health needs which was closing down, so they felt this mitigated the risk somewhat, but they accepted they had not satisfied themselves that people were eligible and safe to work with vulnerable people in the UK.

These concerns were a breach of a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected by measures in place to prevent and control infection. We could see that the service was clean and the registered manager carried out audits to ensure this was the case.

We could see from incidents that the registered manager had taken action to prevent or mitigate future incidents. For example they had installed CCTV in communal areas following one incident.

Is the service effective?

Our findings

People found it difficult to answer when we asked if staff had the skills and knowledge to carry out their role due to communication difficulties. However, mental health professionals were confident staff and the registered manager had the skills and knowledge to care for the people living at the service. A family member told us they felt confident the registered manager had the skills to care for their family member.

We saw that supervision took place regularly and covered training needs and gave an opportunity for staff to discuss issues with the registered manager. Appraisals were in place for staff in post for more than one year.

New staff undertook an induction which consisted of training and shadowing staff. The registered manager told us they had recently attended the Care Certificate assessor's course, which would enable them to assess staff undertaking this nationally recognised qualification for care staff. New staff would take the Care Certificate as part of their induction. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.

Staff undertook training in key areas such as fire safety, first aid, medicine safety and administration, safeguarding and health and safety. We noted that staff had not received training in mental health or managing people's behaviours that can challenge, whilst working for this provider. They had training certificates from previous employers in these areas and had previous experience in working in mental health services. The registered manager was a qualified nurse and had extensive experience in working in acute mental health settings so told us they could provide guidance to staff in this area.

We recommend the provider review core training to include mental health and working with people with behaviours that can challenge training and to stipulate the regularity for refresher training.

Prior to joining the service, people's needs were assessed by the registered manager using information from the referring organisation. We could see that there was detailed pre-assessment information on care records that then informed the provider's care plans. The registered manager worked closely with referring organisations, local mental health services and people using the service to ensure people's needs and choices were assessed and care treatment and support was delivered in line with current legislation, standards and evidence based guidance to achieve effective outcomes for people. Staff were aware of people's needs and could tell us how they met them.

The organisation was small with only two paid care staff and the registered manager, at the time of the inspection. We could see that the team communicated effectively to meet people's needs and deliver effective care and support to people. We could see the service worked closely in partnership with mental health professionals, who spoke highly of the service. Mental health professionals were confident the service alerted them when people's health declined, and told us the staff worked in partnership with them to meet people's needs and achieve effective outcomes.

We could see the registered manager had been in contact with numerous mental health professionals when

one person's mental health had deteriorated and they and their staff had supported this person throughout this period of crisis in conjunction with mental health colleagues. Health professionals told us that the registered manager was very receptive to suggested ways of working with people and two health professionals told us the registered manager was knowledgeable with relevant mental health experience. One said "They do a good job and manage people very well."

We also saw the registered manager had attended ward rounds to support people moving into the service and returning to the service after a period of ill health. There was evidence of the service advocating on people's behalf with a variety of health professionals and one person told us "staff will help me ring the GP if needed." The majority of people living at the service were able to manage their own health needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The majority of people were able to carry out personal activities of daily living by themselves without staff support unless they were going through a period of mental ill health. Some people required support with their laundry or shopping at times and if unwell may need prompting with personal care. Staff understood the importance of consent and told us "people have to give us permission to clean their room, I always wait to make sure they give consent." We saw people's care records were signed. Consent forms were completed to administer medicines to people and the mental capacity of people was noted on care records.

Everyone was at liberty to leave the premises they lived at and no-one was subject to any legal constraint or condition. One person told us "I go out when I want. After medicine I go out."

There was no food or drink commissioned to be provided at the service. People prepared food and drink themselves, although we knew from talking with the staff and people living at the service that some people cooked for themselves, whilst others relied on takeaway food for the majority of their meals. If the person agreed, staff assisted one person with shopping and cooking, but they did not always want that level of support. People were provided with a fridge in their rooms, and there was a communal fridge in the kitchen with milk provided and freezer facilities.

The provider ensured there was tea and coffee at the service with some other basic items of breakfast foods and biscuits. The provider encouraged a contribution to the cost of an evening meal which two people chose to do and staff prepare an evening meal when people wanted to participate. People chose not to socialise or eat together for the majority of the time. For example, despite the provider ensuring there was a meal cooked for everyone on Christmas day; people did not choose to eat together.

One person had issues with food when they were unwell and the provider had ensured staff cooked for this person on a regular basis during this period to ensure they did not become malnourished. Their care record stated to weigh them monthly if there were concerns regarding their weight, but the service had not done this. Following the inspection the registered manager updated care records to provide more information on what this person enjoyed eating in case their health declined in the future and their weight as a result.

Is the service caring?

Our findings

People told us staff were kind and they liked living at the house. One person said "I am happy to stay here." Another said "Like it here, no problem here." We saw caring interactions between the staff and people living at the service. The registered manager was very involved in the day to day running of the service and was kind and caring to people living there. One health and social care professional told us staff "they do that bit extra to meet client's needs." All health professionals confirmed staff were caring to people living at the service. A family member told us they thought their relative was more settled in this service than they had been in others and they found the registered manager caring and kind.

We found there was no background information about each person in two out of the three records we reviewed, but the registered manager told us this information was not available for these people. We found there was no reference in care records to people's religious requirements in relation to food. One staff member told us one person did not eat pork for religious reasons but we had not seen this when reviewing their care records. The service provided a prayer mat for one person to use. We could tell from talking with staff that people's cultural and religious needs were met by staff but this had not always been reflected on their care records. This information had been updated on care records by the time of writing this report.

We saw one person's likes and dislikes were noted on their care records but this was not noted on two other care records we reviewed. The registered manager told us because the service was small this information was shared easily across staff, but acknowledged that it was necessary to record it on care records. Following the inspection the registered manager showed us they had started to put the information they had from previous documents and staff observations onto care records.

Staff told us they showed dignity and respect to people in a number of ways including knocking on the door before entering their room and ensuring they did not speak about private or confidential matters in the communal area. Another staff member told us they respect people for who they are, and the choices they make.

People were supported to be as independent as possible. One staff member told us "[person] needs prompting, and I make sure I don't do everything for him, like cleaning his room or changing his bed, so he stays independent."

People were free to have visitors to the service, but the majority of people chose to socialise with people outside of the service in the community and at other people's houses. One person told us "Sometimes visitors, but [registered manager] tells me all I want."

Up to and including the period of the inspection the living room was used as an area for sleeping in for staff. This meant that from 10pm -7am the living room was not available as the staff member slept in there and people could not access the kitchen. Three out of four people had a kettle in their room to make tea, but one person was not safe to have this facility so they asked other people living in the house to make them a hot drink if they wanted one during this period. We asked people if they minded not having access to the

living room and kitchen during this period as this was also where the TV was located. Of the people who chose to speak with us, this arrangement was accepted and people did not complain regarding this limitation. They told us the TV was rarely used. One person said "have to have tea before the ladies go to sleep. Go to my room with the tea."

However, following the inspection the registered manager had adapted and rearranged the downstairs facilities so staff could sleep in another area which ensured people had 24 hour access to the living room and kitchen. There was a garden for use by people and people had personalised their rooms.

Meetings for people living at the service took place regularly at which people were able to give their views on the way the service was run, although they were not always well attended.

Is the service responsive?

Our findings

Care records were in place and had been updated in the last 12 months or more frequently if required. They covered a range of areas including people's needs for support with daily living, including shopping and cooking, personal care, medicines and mental health.

Although care records did not contain much personalised information the staff could tell us how they met people's needs in a personalised way that was responsive to their needs. For example, they understood people's likes and dislikes, and could tell us about their daily routines. As the service supported people with mental health needs there was a crisis relapse and contingency plan in place for each person. Staff were able to tell us how people's mental health needs manifested themselves and how they had supported people in person centred ways when their mental health had declined. Mental health professionals told us they found the staff and the registered manager responsive and took seriously their professional responsibility to provide care to people living at the service.

Reviews took place regularly of people's care and support needs and were recorded. We saw that when one person was unwell their care needs were reviewed more regularly. Daily records were kept at the service and the office contained information of key events recorded by the manager. The care records at the house we visited were not the most up to date but following the inspection the registered manager replaced these with the most recent documents.

As the service was small with a small staff team there was not a formal key worker system in place but the registered manager told us if the service grew they would introduce this to ensure people were linked more closely with staff of their choosing.

The service was not commissioned to offer activities to people but we could see that the registered manager and staff had tried to organise day trips out over the summer. However people did not want to contribute to the cost or attend so these did not take place. One health and social care professional told us they thought staff managed one person's needs well as they needed a lot of attention and support. One person told us they used their disability freedom travel pass to go and visit relatives and go to visit relatives locally. They also shopped locally and enjoyed cooking as a hobby, and enjoyed playing guitar and singing.

There was a complaints process in place. There was only one formal complaint logged which was dealt with appropriately. The registered manager told us staff dealt with day to day concerns. We asked how people knew about the complaints process and the registered manager told us they were given information when they moved into the service and the opportunity to make complaints was brought up at house meetings. The registered manager told us they had offered to get the complaints leaflet translated for people but they had said they didn't need this. The registered manager told us staff dealt with day to day concerns at each service. We asked people if they had made a complaint or were happy with the service. People told us "It's all OK. No problem." A family member told us they had not had cause to complain but felt confident the registered manager would deal with complaints quickly and be responsive.

The service had not discussed end of life requirements with people, but the provider told us they would develop a policy in this area.

Is the service well-led?

Our findings

The service had been operating since 2015 but had only registered with the CQC in January 2017. The registered manager told us they had experience of running a non-regulated service and were continually learning in this new role. The registered manager told us they had to firm up arrangements for management cover for when they took leave to ensure that the service could continue to run safely in their absence.

We found some ways in which the service was not well led. The registered manager had not notified CQC of two incidents involving the police as required by law. The incident in June 2017 was an oversight, the other occurred as the registered manager had not called the police but a person had been returned to the service by police due to actions they had taken in the local community.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following the inspection the registered manager told us they had familiarised themselves with the requirements and they now felt confident notifications would be sent in as required in the future.

Risk assessments were not all in place to guide staff and the registered manager had not fully understood their obligations to safeguard people using the service from others if there were incidents of violence. Not all quality audits as set out in the provider's quality assurance policy were being undertaken, for example monthly monitoring visits.

However, in other ways the service was well run. Some quality audits were in place. Two health and safety audits were carried out in September and December 2017. The section on medicines had been expanded following the inspection.

Care record files were in good order, and care records were up to date. Reviews were taking place regularly as was supervision with staff. There were policies in place to cover key areas such as recruitment, safeguarding, medicines management and quality assurance.

Staff meetings took place but irregularly and we noted there was a gap between December 2016 and September 2017 when there were no meetings. The registered manager told us they had discussed the incident in June 2017, referred to in Safe domain, with staff but they could not evidence this. The staff team was small and so informal discussions took place which were not always recorded. During the inspection the registered manager was made aware of the need to evidence management actions in all areas to show the service and the management team were continually learning, improving and innovating to provide good care. Staff told us that the registered manager was supportive and available if any issues arose out of hours.

The registered manager had begun to get the formal views of people using the service through questionnaires but had not analysed the information to date. They were aware they needed to get the views of all stakeholders but had not yet done so in the year since registration, although we found one professional had completed a questionnaire and responded positively to the service.

Mental health care professionals told us they were happy with the service provided to the people they had placed there, that the service worked in partnership with them to maintain people's health and they had no hesitation in placing people there in the future, provided they fit the criteria for the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified the CQC of two incidents which had been reported to, or investigated by the police. Regulation 18(1)(2)(f)
Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider could not evidence the proper and safe management of medicines. Regulation 12(1)(2)(h) The provider had not put all risk assessments in place to assess and mitigate risks of people receiving care at the service. Regulation 12(1)(2)(a)(b)
Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider could not evidence that the persons employed were of good character and all checks required had not been undertaken. Regulation 19 (1)(2)(3)